EMS Finance Webinar #3 – The Financial Anatomy of an EMS Call
Question Responses

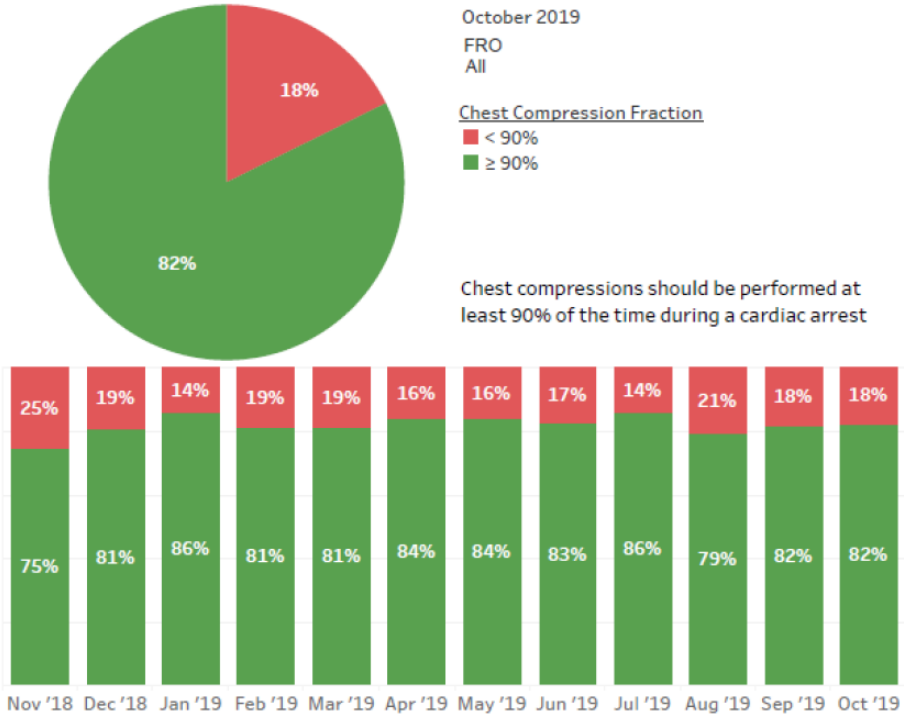
What KPIs are being used to benchmark the field providers?
There are numerous KPIs that can and are being tracked. Clinical measures are used to assure compliance with protocols, appropriate application of the protocols, and compliance with clinical bundles as established by the agency medical control authority.

Clinical KPI Examples from MedStar:

MAEMSA Clinical Bundle Performance Dashboard - STEMI V3	
Agency: MedStar	
STEMI	**Oct-19**
% of suspected STEMI patients correctly identified by EMS and Confirmed at the Hospital	
% STEMI identified at the Hospital, but not by EMS	
% STEMI identified by EMS, without hospital outcomes	
% of suspected STEMI patients w/ASA admin (*in the absence of contraindications)*	91.4%
% of suspected STEMI patients w/NTG admin (*in the absence of contraindications)*	85.7%
% of suspected STEMI patients with 12L acquisition within 10 minutes of ambulance patient contact	74.3%
% of suspected STEMI patients with 12L transmitted within 5 minutes of ambulance transport initiation	51.4%
% of suspected STEMI patients with PCI facility notified of suspected STEMI within 10 minutes of ambulance patient contact	74.3%
% of patients with Suspected STEMI Transported to PCI Center	94.3%
% of suspected STEMI patients with MedStar PSAP time to Cath Lab intervention time < 90 minutes	

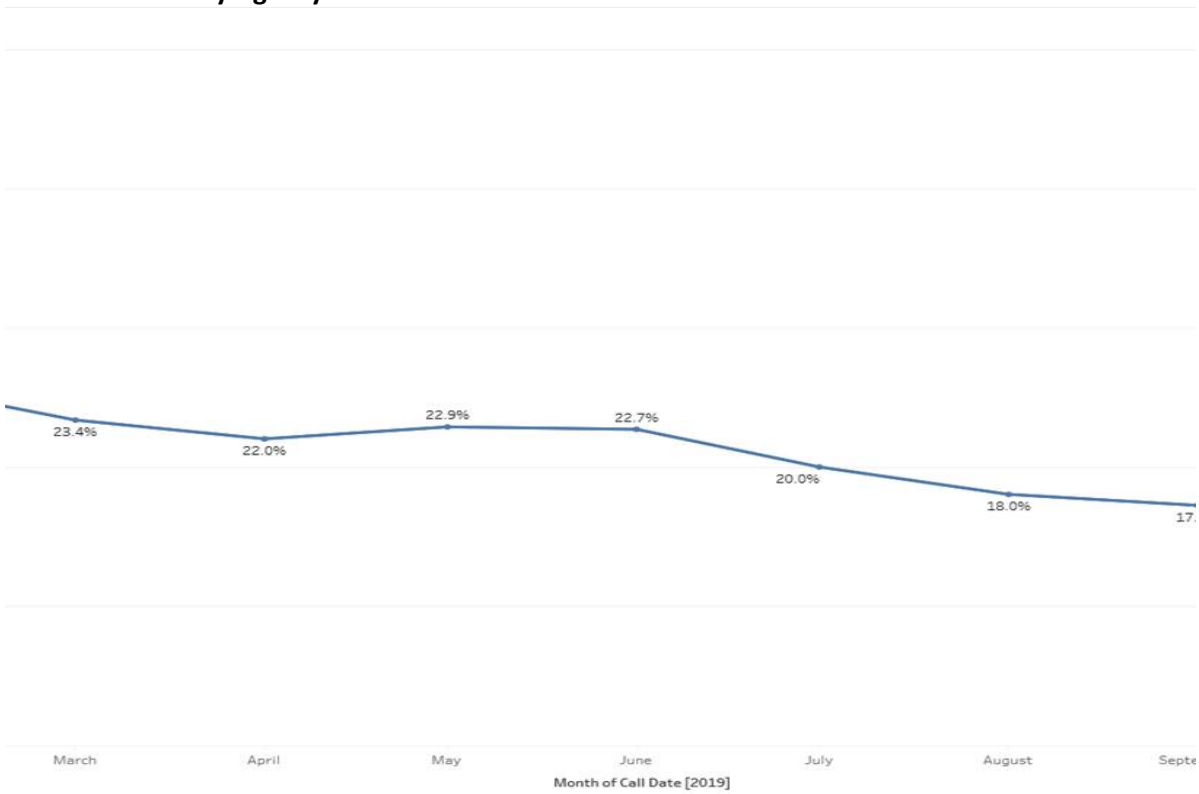
MAEMSA Clinical Bundle Performance Dashboard - OHCA	
Agency: MedStar	
Cardiac Arrest	**Aug-19**
% of recognizable Out-of-Hospital Cardiac Arrests (OHCA) cases correctly identified by Dispatch	84.00%
Median time between 9-1-1 call and OHCA recognition	0:00:37
% of recognized 2nd party OHCA cases that received tCPR	79.2%
Median time between 9-1-1 Access to tCPR hands on chest time for OHCA cases	0:02:17
% of cases with time to tCPR < 180 sec from first key stroke	
System response time < 5 mins for Dispatch-presumed cardiac arrest	
% of cases with CCF ≥ 90%	79.0%
% of cases with compression rate 100-120 cpm 90% of the time	78.0%
% of cases with compression depth that meet appropriate depth benchmark 90% of the time	20.7%
% of cases with mechanical CPR device placement with < 10 sec pause in chest compression	30.8%
% of cases with Pre-shock pause < 10 sec	92.3%
% arrive at E/D with ROSC	16.3%
% discharged alive	5.7%
% neuro intact at discharge (Good or Moderate Cognition)	3.7%
% of cases with bystander CPR	79.2%
% of cases with bystander AED use	0.0%
# of people trained in CCR	

Chest Compression Fraction:



For financial benchmark KPI's, Medstar currently uses completion of patient demographic information in order to ease the billing process. Here's an example of the report generated:

Phone Number Error Rate by Agency:



What are the average days from date of service to when the billing process starts, from date of service to first claim to insurance and date of service to first payment?
It will depend on the payer. For standard Medicare and Medicaid, claims can be sent electronically within a couple of days. For commercial payers, some agencies use processes and companies that monitor a patient's deductible status. Collecting from patients who have to pay out of pocket for medical care because they have not met their deductible is challenging. Sometimes it's better to wait until other providers have billed for service until the patient's deductible has been met, then bill the insurer for the services and get paid by the insurer. That process could take 60 – 90 days. Generally, you can get paid more for the service than if the patient had to pay out of pocket.

Of the $500 MedStar bills for treatment no transport; how much does they collect?
MedStar's collection rate for treatment no transport is 45.3%

Is billing primarily determined based on your narrative?
The narrative is a very important component to documenting medical necessity for the ambulance trip. However, other things are also important such as the documentation of the physical assessment, treatments provided and vital signs. These components can be adequately documented using drop down data fields in your ePCR. The entire document is important.

Is it possible for a BLS agency to bill for a paramedic intercept?
Normally BLS agency, who has an intercepting paramedic providing ALS care, can bill for the ALS service in conjunction with the transport. Most payers will pay the ALS rate in this scenario. Often, the BLS agency will reimburse the ALS intercept agency the difference between the BLS reimbursement and the ALS reimbursement. For example, a diabetic patient, transported BLS, may be reimbursed to the BLS agency at $500. If a paramedic provided ALS care (IV, D10 administration, etc.), the transport is now reimbursed at the ALS rate of $750. The BLS provider pays the $250 to the intercept agency. Paramedic intercept is generally not reimbursable without the transport component.

Our dispatch center does not use EMD codes. They base the billing rate on the narrative only. If it has ALS interventions but less than 3 medications given, it's a certain rate. If there is no ALS intervention, it is a BLS rate. Is this more efficient than using EMD codes? *NOTE: Dispatch and billing is done by separate companies.*
You can bill the higher ALS rate for an ALS assessment, when the call type (EMD or equivalent) warrants an ALS response and assessment, even if BLS care is administered. So, it's likely that you would generate more revenue if you were able to be reimbursed at the ALS rate for an ALS assessment, even if BLS care is provided.

What is the best practice for maximum reimbursement if you are a hospital district that does not balance bill resident patients based on the hospital district contract? *NOTE: Payer mix is 85% Uninsured/Medicare/Medicaid*
Assure you are billing and eligible for the highest rate possible. In the scenario described, you generally cannot balance bill a Medicaid patient. You can only balance bill Medicare patients for their deductible and co-insurance (assuming you are a Medicare enrolled provider), generally a small amount. And, in most cases, private pay patients have a collection rate of about 3-4%. You may need to do a deeper dive into the 85%, to see what % is in each category, to help determine additional best practices.

How does billing differ from medical and psychiatric calls? What if law enforcements is involved?
There is really no difference between medical and behavioral health clinical impressions. The same concepts of BLS or ALS care applies, as well as medical necessity for the ambulance transport. Law enforcement's involvement in the case would have no bearing, even though it may actually help prove medical necessity if the patient needed to be placed in custody for the protection of themselves or others.

As a provider, how much should we relay to patients who are concerned about billing? Should we allow billing and a patients' concern about billing impact type of care?

You should never let finances impact your patient care. There was a time when field providers were encouraged not to discuss billing at all with patients. This was a good practice that allowed patients to make clinical decisions, not financial. Plus, billing is complicated, and it's hard to know what the patient will be financially responsible for at the time of service. However in today's environment of transparency, patient navigation, in-network vs. out of network providers, it may be more helpful for our patients if we allow our field providers to have some basic understanding of finances (the reason why NAEMT and AIMHI are offering these webinars). A future best practice may be to educate field providers on basic billing processes and instead of saying 'we really have no idea the cost to you and your financial responsibility' to a statement like 'the average bill for the ambulance will be about $1,400, but out business office does a great job working with patients to do everything we can to maximize insurance payments to minimize the financial impact to the patient.'

Are there restrictions to photocopying insurance and other documents for attaching to the ePCR?
Generally, no. You must use the same care and caution to assure confidentiality of these records as you do any other Protected Health Information (PHI).

Is MedStar using ImageTrend as an ePCR? if so, what power and situational tools are being utilized?
Medstar uses ImageTrend, send an email to info@medstar911.org to discuss further. Reference this question in your email to be connected with Rick Hyatt, Medstar's Medical Records Manager and ImageTrend expert.

What is ET3?
ET3 stands for Emergency Triage, Treatment and Transport. It is a new voluntary Medicare payment model that allows approved ambulance providers to get Medicare reimbursement for treating patients on scene without transport, or for transport to destinations other than an emergency department. More information is available at https://innovation.cms.gov/initiatives/et3/

Has there been any updates on ET3? Do we know if CMS got the number of participants they expected? Any word on a second round of applications?
CMS is in the process of reviewing the first round of applicants and hopes to make 'soft' announcements of model participants around the first of the year. Selected providers will then enter into written agreements with CMS. Those that complete the process will be announced publicly. There has not been any communication regarding another round of applications as of yet.